Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BRYON NIEBRUGGE MD
PO BOX 121589
ARLINGTON TX 76012

Respondent Name
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative
Box Number 19

MFDR Tracking Number
M4-13-3212-01

MFDR Date Received
AUGUST 2, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Dr. Bryon Niebrugge requests Medical Dispute Resolution in pursuant of Rule 133.305, Medical Dispute Resolution in the above referenced patient's case. These services were requested and prescribed by the Division. The above referenced designated doctor performed the MMI examination and assigned the IR, but he did not perform the range of motion, strength, or sensory testing of the musculoskeletal body area(s)… We have met the burden of proof that the Carrier has received the claim and a copy of the facsimile transmission report to the Carrier."

Amount in Dispute: $250.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier or its agent did not submit a response to the request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 13, 2012	MMI/IR	$250.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 1 – (W1) – Workers Compensation State Fee Schedule Adjustment.
   - 2 – (59) – Process based on multiple or concurrent procedure rules.
   - 1 – No reduction available.
   - 2 – Procedure is reimbursable when requested by carrier or self-insured employer.
   - 3 – Reimbursement has paid in accordance to the Texas Division of Workers Compensation rules. Chapter

129 rule 129.5(a)-(j).

- 4 – The charge for this procedure exceeds the fee schedule allowance.
- 5 – Due to multiple services, this procedure was reduced 50 percent of the fee schedule rate.
- 1 – No reduction available.
- 1 – (18) – Duplicate claim/service.
- 1 – This item previously submitted and reviewed with notification of decision issued to payor, provider (duplicate invoice).
- * - Service rendered does not relate to an accepted compensable injury or disease.
- * - Any request for reconsideration of this workers' compensation payment should be accompanied by a copy of this explanation of review.

Issue

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the service in dispute is June 13, 2012. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on August 2, 2013. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 24, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee***

Dispute Resolution Findings and Decision together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.